# Healthy Families Program Vision Plan Fact Sheet

## 2005-06 Contract Period

**If you have any questions regarding this form, please contact Dinorah Torza at (916) 323-2072.**

Plan Name:_____

Plan contact person for follow up information: _____
(Name and phone number)

1. Please complete the Optometrists chart below.

| Optometrists | 2002 | 2003 | 2004 |
|---|---|---|---|
| Total number of optometrists in the provider network as of January 1st. | # _____ | # _____ | # _____ |
| Number of optometrists added to the provider network during the calendar year. (Indicate number and percentage.) | # _____ | # _____ | # _____ |
| | % _____ | % _____ | % _____ |
| Number of optometrists that left the provider network during the calendar year. (Indicate number and percentage.) | # _____ | # _____ | # _____ |
| | % _____ | % _____ | % _____ |
| Total number of optometrists in the provider network as of December 31st. | # _____ | # _____ | # _____ |

2. Please complete the Ophthalmologists chart below.

| **Ophthalmologists** | **2002** | **2003** | **2004** |
|---|---|---|---|
| Total number of ophthalmologists in the provider network as of January 1st. | # _____ | # _____ | # _____ |
| Number of ophthalmologists added to the provider network during the calendar year. (Indicate number and percentage.) | # _____ | # _____ | # _____ |
| | % _____ | % _____ | % _____ |
| Number of ophthalmologists that left the provider network during the calendar year. (Indicate number and percentage.) | # _____ | # _____ | # _____ |
| | % _____ | % _____ | % _____ |
| Total number of ophthalmologists in the provider network as of December 31st. | # _____ | # _____ | # _____ |

3. How many vision service locations or "outlets" does the plan include in the network? What percentage of vision locations is available to Healthy Family Program members through the plan that are accepting new patients as of January 1, 2005?

   Total number of vision service locations _____

   Number accepting new patients _____

   Percentage _____

4. Does the plan require all providers to have on-site dispensing capability? If not, what percentage of the provider network does not have the on-site dispensing capability?

5. Please complete the Vision Plan Providers Network Capacity Chart. This chart requires plans to list the percentage of providers accepting new patients and the estimated number of members that the providers can serve by county as of January 1, 2005

**Vision Plan Providers Network Capacity Chart**

**Vision Plan Name:**_____

| COUNTY | Number of Optometrists | Number of Optometrists accepting new patients | Percentage of Optometrists accepting new patients | Estimated number of patients that can be served in each county |
|---|---|---|---|---|
| Alameda | | | | |
| Alpine | | | | |
| Amador | | | | |
| Butte | | | | |
| Calaveras | | | | |
| Colusa | | | | |
| Contra Costa | | | | |
| Del Norte | | | | |
| El Dorado | | | | |
| Fresno | | | | |
| Glenn | | | | |
| Humboldt | | | | |
| Imperial | | | | |
| Inyo | | | | |
| Kern | | | | |
| Kings | | | | |
| Lake | | | | |
| Lassen | | | | |
| Los Angeles | | | | |
| Madera | | | | |
| Marin | | | | |
| Mariposa | | | | |
| Mendocino | | | | |
| Merced | | | | |
| Modoc | | | | |
| Mono | | | | |
| Monterey | | | | |
| Napa | | | | |
| Nevada | | | | |
| Orange | | | | |
| Placer | | | | |
| Plumas | | | | |
| Riverside | | | | |
| Sacramento | | | | |
| San Benito | | | | |
| San Bernardino | | | | |
| San Diego | | | | |
| San Francisco | | | | |
| San Joaquin | | | | |
| San Luis Obispo | | | | |
| San Mateo | | | | |
| Santa Barbara | | | | |
| Santa Clara | | | | |
| Santa Cruz | | | | |
| Shasta | | | | |
| Sierra | | | | |
| Siskiyou | | | | |
| Solano | | | | |
| Sonoma | | | | |
| Stanislaus | | | | |
| Sutter | | | | |
| Tehama | | | | |
| Trinity | | | | |
| Tulare | | | | |
| Tuolumne | | | | |
| Ventura | | | | |
| Yolo | | | | |
| Yuba | | | | |

6. Please respond to the following questions and describe the process used for delivering vision services.

| **I. Members Access to Services** |
|---|
| a) Can members see ophthalmologists without a referral for annual eye examinations? |
| b) Describe how the plan will implement the contractual requirement of informing new members how to access services. (See Exhibit A, Item II.E.) |
| c) Describe how the plan will assures that members who have had an initial eye examination continue to have annual vision exams. |
| d) What accessibility guarantees are required in your plan's contracts with providers? For wait time for appointments, language capabilities, hours of operation. |
| **II. Member Cost Sharing** |
| a) Describe how the plan will determine its designation of the number and types of frames available at the $5 copayment level. |
| b) Describe how the plan will implement the federal government's requirement to exempt American Indian and Alaska Native children in HFP from all copayments in the program. |
| **III. Member Complaints and Grievances** |
| a) Describe the plan's policies and procedures for the submittal, processing and resolution of member complaints and grievances. Include in the definition the Plan's mechanism for documenting, tracking and ensuring that member complaints and grievances are acknowledged within the required timeframes. |
| b) How will the plan contact member/applicant regarding complaints? (For example through the use of a designated staff working solely on complaints/grievances.) Please include how non-English speaking members will be assisted. |

| **IV. Member Services** |
|---|
| a) Describe any unique customer service features the plan offers to members. (For example, extended provider office hours.) |
| b) Please describe how the plan will monitor and evaluate call waiting time and the busy or abandonment rates on your customer service phone lines. |
| c) Describe how the plan will determine if there is sufficient bilingual staff on the telephone lines to serve the members in all the threshold languages. |
| d) Describe the process that will be used to ensure compliance with the contractual requirement to provide an Identification Card, Provider Directory and Evidence of Coverage booklet to applicants, on behalf of members, no later than the member's effective date of coverage. What process will be used to track your performance in this area? |

7. Describe any agreements contemplated or in progress between the plan and other parties which may affect the plan's ownership, corporate structure or management during the January 2005 through June 2006 time period (as allowed by State and Federal Law).

8. Describe any restrictions or pending reviews by state (including the Medi-Cal program) or federal authorities for non-compliance with state or federal regulations or contracts for medical services.

This 2005 Vision Plan Fact Sheet for the Healthy Families program must be signed by the person authorized to sign the vision plan's contract.

To the best of my knowledge, all statements and data reported by _____ (Vision Plan name) in this Vision Plan Fact Sheet 2005/2006 for the Healthy Families Program are true and accurate. I understand that all responses to questions included in the Fact Sheet except items # 7 and # 8 may be included in comparative charts in the Healthy Families Program brochure or other public documents produced by MRMIB.

Signed

_____
Name

_____
Title

_____
Date